Collating these results of experiment with those of clinical observation, Dr. Ruggi agrees with Velpeau that, in most cases, ligature of the external carotid is not sufficient to restrain hemorrhage from injury of one of the branches of the external or internal carotid, while the application of a ligature to one or the other of the secondary carotids absolutely interrupts all secondary circulation. He relates the following case in support of this view.

A man was admitted into hospital with neuralgia of the left inferior dental nerve, for which excision of a portion of the nerve was performed. Ten days after the operation, the patient had repeated and abundant hemorrhage from the mouth. The source of the bleeding could not be accurately determined, but was supposed to be a rupture of the inferior maxillary artery, produced by ulceration in the course of the operation-wound. The right side of the face was enormously swollen and pale, the pulse was small and intermittent, the limbs were cold, the voice was feeble. Dr. Ruggi tied the common carotid artery 2½ centimetres (about an inch) from its origin; he also placed a ligature on the superior thyroid. The hemorrhage did not return. Along the course of the left external maxillary and superficial temporal, all pulsation was absent. The patient left the hospital perfectly cured.—*London Med. Record*, Nov. 15, 1877.

Diagnostic Value of Pulsation, à propos of a Case of Pulsating Tumour of the Upper End of the Left Tibia.

In the *Commentario Clinico di Pisa* for May and June, 1877, Professor PASQUALE LANDI, of that city, analyzes the six cases collected by Nélaton, and considered by that surgeon entitled to the name "true aneurism of bone," four other cases collected by Volkmann, and related in Pitha and Billroth's *Handbook;* a case of Cappelletti's (Trieste); and, lastly, one of Landi's own, making twelve in all.

The tibia was the bone affected in nine cases, in eight of which the head of the bone was the seat of the tumour, while in the ninth (Scarpa's) this was below the head. The lower end of the femur in two cases, and the head of the humerus in one (Richet's), completed the list. Except two, the cases ran a slow course; in one half an injury is related, and in the other half is wanting.

All these intra-osseous tumours pulsated, except Richet's, where, however, a blowing murmur was audible. In one other only (that of Carnochan, lower end of the femur) was there a bruit.

In nine the tumour grew before the thirtieth year, and in two at the fifty-fourth and sixty-third; while in one no age is given. All resembled ordinary aneurism, in the feature of distensile pulsation (in the one case replaced by a murmur, with which it was combined in another), and in the cases of Pearson and Scarpa were actually diagnosed as aneurism of the anterior tibial; but the anatomical examination failed in every case to show the artery implicated. They were all, moreover, clinically different from ordinary aneurism in the characteristic feature of a bony wall, more or less imperfect, no doubt, but present in each. In two only did complete cure result from ligature of the main arterial trunk (case of Lallemand and that of Roux). In two others, after ligature of the main artery, the tumour ceased to pulsate, but remained diminished in one case (that of Largout and Fleury) and fluid in the other (Nélaton's).

In three cases the ligature failed, and recurrence took place (Dupuytren, Carnochan, Cappelletti); but the consequent amputation was successful. Primary amputation succeeded in two (Parisot and Scarpa), but fatal recurrence took place after five years in the case of Scarpa. Two primary amputations were fatal (Pearson's and Richet's).

He discusses at great length the clinical signs, the results of treatment, and the pathological anatomy of this very rare class of cases, more especially in relation to their origin in a new growth, such as myeloid, or in some cases a malignant central osteo-sarcoma; and offers the opinion "that osteo-aneurism does not really exist, and that certain symptoms, characteristic of ordinary aneurism, are but accessory phenomena in the case of certain new growths of a nature more or less malignant."

His own case he diagnosed to be pulsating myeloid tumour of the head of the tibia, and microscopical examination confirmed the opinion. Amputation proved successful. The four cases of Professor Gherini are then briefly given. (1) Pulsating tumour of innominate bone, mistaken for abscess and punctured, but bleeding arrested. Ultimate death from exhaustion, the tumour spreading greatly. No examination. (2) Myeloid pulsating tumour of patella. (3) Pulsating tumour of lower end of femur. (4) Pulsating tumour of head of tibia. Thus in only one of these was the exact nature of the growth made out, but cases 3 and 4 are judged by Professor Gherini, from their resemblance to case (2), to be probably of the same nature.—*London Med. Record*, Nov. 15, 1877.

Sarcoma of the Median Nerve; Resection without Disturbance of Sensation.

KRAUSSOLD relates in the *Archiv für Klinische Chirurgie*, Band xxi., the case of a boy aged five and a half, who, in consequence of severe and painful pressure with the hand ten months before, had a tumour of the upper arm. It had gradually developed, and was about as large as a hen's egg, lying in the right internal bicipital furrow, and reaching from the epicondyle to the upper third of the arm; there was distinct fluctuation. There were no disturbances of motion or of sensation in the forearm and hand. The swelling being supposed to be an abscess, an incision was made, when it was found that it was a sarcoma, the interior of which had become disintegrated; it was encapsuled, but, becoming spindle-shaped above and below, was found to be continuous with a thick cord which was recognized by its position as the median nerve. In extirpating the tumour, nearly eleven *centimetres* (about 4.3 inches) of the median nerve were removed. Some hours after the operation, the only disturbance of motion that could be detected was inability to bend by voluntary action the index finger and thumb; all the other motions of the fingers, hand, and forearm, as well as the sensibility of the limb, especially in the region of distribution of the median nerve, were normal. These conditions remained after the healing of the wound. The tumour was a small-celled sarcoma; a few changed nerve-fibrils were scattered within it, while others lay in its capsule. After recounting the symptoms expected to follow division of the median nerve, Kraussold comes to the conclusion that the absence of most of them in the present case may be explained in one of two ways: either by a pre-existing anomaly or by the numerous nervous anastomoses. The first supposition is rendered improbable by the fact that the divided median nerve was of normal thickness. The second assumption has more in its favour; the long duration and gradual development of the disease may have given time for a further formation of anastomoses. This case indicates the necessity for a very careful criticism of the descriptions of the remarkable results of suture of nerves, and of regeneration of nerves and restoration of their functions after division.—*Brit. Med. Journ.*, Nov. 3, 1877.